Rosario Counseling & Associates, PLLC
5909 Falls of Neuse Road Suite 208 Raleigh, North Carolina 27609
Office (919) 649-5882 | Fax (919) 521-8175

DEMOGRAPHIC INFORMATION

Clients Name_____DOB_____

Spouse/Parent(s) Name_____DOB_____

☐Spouse ☐Parent

Address_____

CONTACT INFORMATION:

Contact # (H) _____ (C) _____ (W) _____

Email_____

Secondary Email If Needed_____

Emergency Contact _____ Phone _____

Relationship _____

INSURANCE INFORMATION:

If Medicare is your primary insurance please see someone in our administrative office, prior to completing this form.

Primary Insurance _____**Policy #**_____

Primary Policy Holder Name_____

Primary Policy Holders DOB_____

If you have a secondary insurance please bring it along with your primary card.

Are both above Parties covered under the above insurance ___Yes ___ No If not please list the other insurance plan.

Whose Plan is this? _____

Name of Insurance _____

Policy # _____

General Information: **PLEASE COMPLETE information below:** *Very important information. Thanks*

Reason for Visit_____

How were you referred to our office? _____

Rosario Counseling & Associates

Robin Rosario, MA, LPCS

5909 Falls of Neuse Road Suite 208
Raleigh, NC 27609
(919) 649-5882

Psychological Testing
Adult, Adolescent, and
Child Counseling

Professional Disclosure Statement

I am pleased that you are considering the counseling services that I provide. Counseling is a personal interaction that deems thoughtful consideration. The following information is designed to provide pertinent details to ensure that you know what to expect from counseling and our therapeutic relationship.

I earned a Master of Counseling Education/Counseling Psychology degree (M.A.) from Western Michigan University in 1990. While in Michigan I received the status of Licensed Professional Counselor - 6401001052. Since 1990, I have worked as a trained professional counselor. I am licensed by the North Carolina Board of Licensed Professional Counselors as a Licensed Professional Counselor Supervisor, License # 4249.

Individual, Couple and Family Counseling are part of the services that I offer as well as Psychological Testing.

Theoretical Counseling Approach *Client initials _____*

Counseling is an opportunity to sort our problems, generate solutions as well as change unhealthy thoughts, feelings and behaviors. We will need to specify goals setting an orderly approach to reaching those goals. While goals vary in kind and value, the process of achieving them is part of the work we do in counseling. We will evaluate your progress and, if necessary, redesign your treatment plan, goals and methods.

As a trained mental health professional I have worked in both outpatient and inpatient care. I find problems have psychological, emotional, behavioral and spiritual dimensions. In holding to biblical truth I utilize cognitive-behavioral, rational emotive, and reality therapy approaches. These are well established, researched, and respected therapies.

In order to gain maximum benefits from therapy your active involvement in and out of therapy sessions is essential. I may ask you to complete assignments, exercises or journals. Progress is largely dependent on your willingness, motivation and ability to make personal changes. Occasionally rapid changes occur, but more often progress is a gradual process.
I am a professionally trained to work with clients ranging from those struggling with daily life problems to those suffering a crisis in need of intervention.

Our initial session is a 60 minute Diagnostic Interview, where I will offer you initial impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. If your situation is beyond my expertise/scope of services, I will assist you in finding appropriate services. Regular sessions run about 45-60 minutes.

Dual Relationships *Client initials _____*

Therapy sessions may be deeply personal psychologically and emotionally however keep in mind that we have a professional relationship rather than a social one. You will be best served if our relationship stays professional and if our sessions concentrate strictly on your concerns. You will learn a great deal about me as we work together in my professional role.

Confidentiality *Client initials _____*

Confidentiality is an essential part of our clinical relationship. Our office offers a team approach to counseling where it may be appropriate to share your information with another counselor or supervisor within our practice involved in your treatment plan for therapeutic reasons. Information given to Rosario Counseling & Associates, including the scheduling of appointments, content of counseling sessions, and any records to name a few, are confidential as outlined by HIPAA (Health Insurance Portability & Accountability Act), along with our State laws & Professional Ethics that regulates our counseling practice with few exceptions.

The special circumstances that are an exception in which Rosario Counseling & Associates are required to contact the appropriate entity to handle are the areas that follow: Child or Elder abuse, Suicidal Ideation, Homicidal Ideation, or Court Order. In the event a client has both a communicable and life threatening disease and another individual(s) are at a serious risk of contracting a contagious/life-threatening disease a counselor may be justified in disclosure. Otherwise, your personal information will not be released to any entity or person(s) without your written consent.

Scheduling Appointments/Cancellations and Length of Sessions *Client initials _____*

Counseling appointments are scheduled in advanced. I will make every effort to see you as soon as possible. The length of a counseling session is 45 or 60 minutes depending services selected. When calling to cancel or reschedule please advise the office at least 24 hours in advance. I maintain a 24 hour, 7 day a week voice mail thus messages will suffice if you leave the time and date of your cancellation. If the office does not receive advance notice, you may be responsible for paying for the missed appointment.

Fees and Methods of Payment *Client initials _____*

-60 minute Initial Diagnostic Session is **$135**
-60 minute session is **$110** 45 minute session is **$90**
-In proven financial hardship, we offer a scholarship or *fee* adjustment based on proven income.
To learn more inquire with our office administrator.
-Methods of payment accepted cash, check, benefit cards and credit card.

Billing and Insurance Reimbursement *Client initials _____*

As a courtesy to our clients our office will file insurance claims for policies that cover outpatient out of network counseling. To determine coverage call the phone number on your insurance card and request to verify benefits. Clients pay the full amount at the beginning of each session and the reimbursement from the insurance company is returned directly to you. If this is a problem please inform me at our initial session. Please remember that you are responsible and not your company for paying the fees agreed upon. Insurance companies and employee assistance programs often require that I diagnose your mental health condition and indicate that you have an "illness" before they will agree to reimburse you. I will inform you of this diagnosis. Any diagnosis made becomes a part of your insurance record.

Emergency Protocol Client initials _____

In the event of a life-threatening emergency immediately call 9-1-1. If you need to speak with a mental health professional while our office is closed, contact Holly Hill Hospital at (919) 250-7000.

Ethical Conduct *Client initials _____*

Robin practices the ethical standards of her profession as stated by the AACC and ACS. If you are dissatisfied, please inform Robin immediately. If you have a complaint and cannot resolve this problem with Robin, you can contact the North Carolina Board of Licensed Professional Counselors, PO Box 77819, Greensboro, NC 27417 or call 844-622-3572.

Client/Counselor Agreement

Please sign and date this form, indicating you understand and accept the content herein. The office will provide a copy to you. If you have any questions/concerns regarding the professional disclosure statements please ask prior to signing this document.

_____ _____
Clients Signature *Date*

_____ _____
Therapist Signature *Date*

Rosario Counseling & Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Rosario Counseling & Associates.

_____ _____

Signature of client (or personal representative) Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

  _____

  _____

  _____

This form will be retained in your medical record.

Rosario Counseling & Associates, PLLC

Patient Financial Responsibility Policies

Fees for Services:
Initial session $135
Psychotherapy $110 (53 – 60 minutes)
Psychological test & assessment – cost varies

Non-Sufficient Funds - $25 fee; **Returned Check** - $ 15 fee

Accurate Account Information: I recognize that it is my responsibility to inform Rosario Counseling & Associates PLLC, (hereby known as RCA), of my address, phone number, credit card and insurance information or any changes as long as I remain a client with RCA and/or have an account balance.

Accepted Forms of Payment: Cash, Check, Credit Card (Visa, MasterCard), or Health Benefit/Flex Cards

Responsibility for Payment: I understand and agree that I am responsible to pay charges and balances incurred on my account or the account of my minor child for health care related services provided by RCA. At the time services are rendered payment for services are due to RCA.

Secure Payments: All credit card information is secure through an integrated system allowing for quick confidential payment for services at check-in. In addition patients can pay invoices received through the encrypted patient portal. It is an RCA policy credit card authorization to conveniently pay for charges that are not covered by your insurance carrier. I agree to authorize RCA to use my credit card for outstanding or unpaid balances, unanticipated missed appointments, late cancellations, charges for insufficient funds for checks, and unmet deductibles etc.

Payment for Minor Children/Teenagers services: The accompanying parent or adult of the minor is responsible for full payment at the time service is provided. In the event of divorced or separated parents, please do not place our office in the middle of relationship disputes. I understand and agree to pay in full all charges incurred for the provision of health care and health care related services to my minor child at the time the services are provided.

Insurance Benefits - *deductibles, copays and coinsurance*: I understand I am responsible to provide my current insurance card to RCA, granting permission to bill my insurance company. RCA will collect the estimated amount (deductible, copay or coinsurance) when services are rendered submitting the charges for services to the insurance carrier or third party payer. I understand I am responsible for denied or outstanding balance upon insurance/third party reimbursement. I am responsible to pay my RCA account not insurance.

Authorization for Assignment of Insurance Benefits: I authorize payment of insurance benefits, directly to RCA for services rendered that otherwise would be payable to me.

Missed Appointments/Late Cancellations: I understand that it is my responsibility to provide RCA with 24-hour notice for cancelling an appointment or I may be charged for a missed appointment/late cancellation at the full rate, which is not covered by insurance.

Financial Hardships: If you are in financial hardship and do not have insurance to offset the cost of professional counseling notify the administrative office to determine if you are a candidate for a scholarship.

Testimony: Witness
There will be a charge in the event you subpoena/request a therapist for their testimony as a witness. The fee is $2,640.00 plus a per diem for meals and travel expenses. In addition, fees associated with a hotel stay will be incurred if a hotel is needed when the courthouse is over 45 minutes from therapist's home. All fees must be paid 7 days advanced of court date. These fees are not refundable even in the case of a continuance. These services are not reimbursable through insurance.

Signature of Client: _____ Date:_____